AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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December 14, 2007

Gary Jackson
CMS/DQEHO
7500 Security Blvd.
Mail Stop S2-26-12
Baltimore, MD 21244

RE: 2007 Arizona Medicaid Quality Assessment and Performance Improvement Strategy Revision

Dear Mr. Jackson:

In accordance with 42 CFR 438.202, the Arizona Health Care Cost Containment System (AHCCCS) is submitting its 2007 Quality Assessment and Performance Improvement Strategy revision. The content has been updated to reflect: 1) progress on current projects, 2) current successes and 3) future endeavors. The framework comports to the CMS 2006 Medicaid Quality Strategy Toolkit.

Should you have any questions, please contact Kim Elliott, Quality Management Administrator at (602)417-4782.

Sincerely,

Anthony D. Rodgers
Director
AHCCCS

Enclosure

cc: Athena Chapman, CMS
Kate Aurelius, Assistant Director
Marc Leib M.D., Chief Medical Officer
Kim Elliott, Quality Management Administrator
Claire Sinay, Office of Medical Policy and Programs

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

TABLE OF CONTENTS

PREFACE

In accordance with 42 CFR 438.200 et. seq., the federal regulation that is specific to Medicaid Managed Care, the AHCCCS Quality Strategy was established in 2003. This federal regulation was enacted as a result of the Balance Budget Act (BBA). It is a coordinated, comprehensive, and pro-active approach to drive quality throughout the AHCCCS system by utilizing creative initiatives, monitoring, assessment, and outcome-based performance improvement. The Quality Strategy is designed to ensure that services provided to members meet or exceed established standards for access to care, clinical quality of care, and quality of service. It is designed to identify and document issues related to those standards, and encourage improvement through incentives, or where necessary, through corrective actions. The quality strategy document adheres to the recommended Centers for Medicare and Medicaid Services (CMS) format.

AHCCCS develops and approves the Quality Strategy through the identification of specific goals and objectives as demonstrated throughout this document. The Quality Strategy provides a framework for the overall goal of improving and/or maintaining the members' health status as well as fostering the increased resilience and functional health status of members with chronic conditions. Members, the public, and stakeholders provide input and recommendations regarding the content and direction of the Quality Strategy. The Agency maintains the ultimate authority for overseeing the Quality Strategy management and direction.

The Quality Strategy incorporates the following components as required by the B.B.A. regulations. AHCCCS must:

- Have a strategy for assessing and improving the quality of managed care services offered by all Contractors;
- Document the strategy in writing;
- Provide for the input of members and stakeholders in the development of the strategy, including making the strategy available for public comment before adopting it as final;
- Ensure compliance with standards established by AHCCCS, consistent with the regulations;
- Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy as often as AHCCCS considers appropriate;
- Provide to CMS a copy of the initial strategy, and, whenever significant changes are made, a copy of the revised strategy; and
- Provide to CMS regular reports on the implementation and effectiveness of the strategy.

The management responsibilities for the Quality Strategy are shared by several Divisions/Offices within the Agency. Internal and external collaborations/partnerships may be utilized to address specific initiatives and/or issues. The AHCCCS Administration oversees the Quality Strategy's overall effectiveness and performance of its Contractors. AHCCCS is responsible for reporting

Quality Strategy activities, findings, and actions to members, other stakeholders, Contractors, the Governor, legislators, and the Centers for Medicare and Medicaid Services (CMS).

The Quality Assessment & Performance Improvement Strategy document is very closely aligned and interfaces with:

- The External Quality Review (EQR) report requirements as defined in 42 CFR 438.364. There are three mandatory activities which include 1) the review of the MCO/PIHP compliance with specified standards for quality program operations, 2) the validation of state-required performance measures, and 3) the validation of state required performance-improvement projects. AHCCCS is unique in the approach it uses for EQR activities. As a point of clarification, AHCCCS has, over the past 25 years, developed significant in-house resources, processes and expertise in monitoring its Managed Care Contractors, and thus performs most of the EQR functions. AHCCCS contracts with External Quality Review Organizations (EQROs) to review the AHCCCS staff quality monitoring activities. The EQRO is tasked with preparing an independent report that summarizes each AHCCCS Contractor's compliance, strengths and weaknesses for review and follow through by AHCCCS staff as warranted.

  The EQR reports encompass specific details of the assessment, results and recommendations related to the goals and strategies found in this document. This information is used to assess the effectiveness of the currently stated goals and strategies and provide a roadmap for potential changes and new goals and strategies.

- Quality strategies and deliverables are detailed in AHCCCSA's 1115 Waiver Report. Progress and updates for the quality strategy are reported in Attachment II, "Quality Assurance/Monitoring Activity" of the section 1115 Waiver quarterly report.

AHCCCS takes its responsibility as the catalyst and overseer of the Quality Strategy very seriously. The AHCCCS Administration has and will continue to collaborate with its stakeholders to optimize the health outcomes of its members.

Links to documents related to the body of the Quality Strategy are as follows:

- AHCCCS 1115 Waiver 2006—2011
  http://www.azahcccs.gov/Publications/PlansWaivers/1115Waivers/default.asp

- AHCCCS Five Year Strategic Plan 2008
  http://www.azahcccs.gov/Publications/StrategicPlanning/

- AHCCCS Contracts
  http://www.azahcccs.gov/Contracting/ContractAmend.asp

- AHCCCS Reports
  - AHCCCS Performance Measure and Performance Improvement Project Reports
    http://ahcccsdev/Studies/
  - External Quality Review Organization Reports
    http://www.ahcccs.state.az.us/Publications/Reports/#EQRO
  - Quarterly Report to CMS
    http://ahcccsdev/Publications/Reports/default.asp
  - AHCCCS E-Health Initiative
    http://www.azahcccs.gov/eHealth/

SECTION I: INTRODUCTION

A. Quality Strategy Overview

1. History

The Arizona Health Care Cost Containment System (AHCCCS) has operated under an 1115 Research and Demonstration Waiver since 1982 when it became the first statewide Medicaid managed care system in the nation. The AHCCCS Medicaid program began its acute care program at that time. The AHCCCS Long Term Care System (ALTCS) was added in December of 1988 for persons with developmental disabilities in January of 1989, ALTCS was expanded to include the elderly and physically disabled (EPD) populations. On October 1, 1990, AHCCCS began incorporating comprehensive behavioral health services, beginning with coverage of seriously emotionally disabled children under the age of 18 years who required residential care. Over the next 5 years, behavioral health coverage was extended to all Medicaid-eligible persons.

Arizonans' approval of Proposition 204 added additional groups to the acute care population in 2001. As of October 1, 2007, there are approximately one million AHCCCS members. Fifteen Managed Care Organizations (MCOs) and two Prepaid Inpatient Health Plans (PIHPs) serve AHCCCS managed care members statewide. PIHPS are limited to providing behavioral health and Children's Rehabilitative Services. Within the AHCCCS program, MCOs and PIHPs are called "Contractors."

The AHCCCS Administration intends to increase members' health security by its emphasis on the following:

a. Customer-focused Contractors as demonstrated by:

    1) Choices for members

    2) High member satisfaction, and

    3) Incentives for wellness.

b. Continuous improvement in quality of care

c. Integrated service networks and community resources

d. Effective cost management, and

e. Focus on member/provider assistance and service support by:

    1) Maximizing information resources

    2) Continuing emphasis on disease management

3) Continuing preventive care to reduce risk, and

4) Enhancing e-health capabilities.

2. Mission

The Quality Assessment and Performance Improvement Strategy is founded on AHCCCS' mission of "reaching across Arizona to provide comprehensive, quality health care for those in need." Inherent in carrying out this mission is the AHCCCS Administration's commitment to drive quality through the development of the Quality Strategy. The Agency then establishes its goals, objectives and timetables for health care improvements. The AHCCCS Administration has had a formal Quality Initiative and Performance Improvement Plan since 1994. This commitment to quality was the foundation for fulfilling the quality strategy requirements initiated by CMS in 2003.

3. Vision

AHCCCS has long been respected as an innovator in the area of Medicaid managed care. It is AHCCCS' goal to remain a leader by increasing its pro-activity in the quality arena. The Agency's vision includes:

a. Advocating for customer-focused health care;

b. Leading the development of new quality of care initiatives and quality improvement strategies;

c. Continuing its roles as an innovator of health coverage and as a valued partner and collaborator in improving the health status of Arizonans;

d. Expanding its role as a facilitator of collaborative health care initiatives that leverage public and private resources;

e. Connecting uninsured and at-risk Arizonans to affordable health care coverage;

f. Maintaining its role as a good steward of public and private health care finances;

g. Increasing its role as a health information resource; and

h. Providing an optimal work environment for its employees.

4. Process For Overall Quality Strategy Development, Review And Revision

The AHCCCS Administration has built its quality structure over time by means of its adherence to federal requirements, continual review of applicable national standards and national and/or regional trends, collaboration with partners, and its own experiences. The Quality Strategy

encompasses AHCCCS acute and long-term care Contractors, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the ADHS Children's Rehabilitative Services (CRS). It also incorporates measures to improve the Agency's internal processes involving enrollee information, monitoring and evaluation.

The Agency uses the steps described below when considering the addition of new clinical and non-clinical projects to enhance the well-being of its members. Using a workgroup process, the AHCCCS Administration first engages in a review of the current components of the Agency's quality initiative, examining the various processes in place to develop, review and revise quality measures. Second, a review is completed of AHCCCS materials that illustrate the focus on quality, which is central to the Agency's mission and vision. Finally, the Quality Strategy document was developed to include the overall strategic goals and objectives related to quality, the quality-improvement approach of the Agency, and the quality measurement initiatives and overview processes.

The specific components of the overall AHCCCS Quality Strategy are as follows:

a. Facilitating Stakeholder Involvement

The success of AHCCCS can be attributed, in part, to concerted efforts by the Agency to foster collaborative partnerships with its sister agencies, Contractors (Administrators and Medical Directors)**,** providers (physicians, other professionals, and paraprofessionals) and the community (advocacy groups, non-profit and for-profit groups). Venues for suggestions and feedback, such as public forums, member councils, and meetings with Contractors and providers, are regularly sponsored by the AHCCCS Administration. In order to provide for public involvement and commentary on changes resulting from the BBA regulations, the AHCCCS Administration includes the Contractors in discussions regarding strategies and implementation of the BBA regulations. Examples include:

1) Spouse as Paid Caregiver – Consumers and advocates had been requesting that AHCCCS research the "spouse as a paid caregiver" concept to continue to expand the HCBS network within ALTCS and allow more choice for ALTCS members. AHCCCS requested and received a waiver from CMS to allow members to select their spouse to be their paid caregiver. Although this may not be a viable option for many members, there are those member/family situations (e.g., working spouse needed to quit his/her job in order to provide the seven day a week, 24 hour per day intermittent care) that will be able to benefit from this option.

2) Self Directed Attendant Care – Consumers and advocates have been requesting that AHCCCS develop a Self Directed Attendant Care Program so that members may have more control and management of their needs. Led by an ALTCS Program Contractor, the development work teams have included members, providers, advocates and AHCCCS Contractors. Self Directed Attendant Care will encourage members to make decisions that will more likely result in positive outcomes. Stakeholder input has been an integral part of the planning and development of Self Directed Attendant Care.

b. Developing And Assessing The Quality And Appropriateness Of Care/Services For Members

The AHCCCS Administration develops measures and assesses the quality and appropriateness of care/services for its members using the following processes:

1) Identifying priority areas for improvement

The AHCCCS Administration regularly establishes key clinical and non-clinical areas on which to focus future efforts. This is done through analysis of state and national trends and in consultation with other entities working to improve ~~the~~ health care in Arizona such as the Medicare Quality Improvement Organization (QIO), community leaders, other state agencies, and AHCCCS Contractors.

2) Establishing realistic outcome-based performance measures

The AHCCCS Administration establishes minimum performance standards, goals, and benchmarks based on national standards whenever possible. Contractors are expected to achieve the minimum performance standard for performance measures. Performance measure reports, such as that for immunizations, may compare the Contractor results with each other and with Medicaid and commercial health plan national averages. The rationale for establishing these measures is for Contractors to develop methods to continuously increase the well-being of their respective populations through the removal of barriers to care and ongoing process improvement.

Each Contractor is expected to conduct Performance Improvement Projects (PIPs) in clinical care and non-clinical areas that are expected to have a favorable impact on health outcomes and member satisfaction. Utilizing financial, population, and disease-specific data and input from the Contractors, the AHCCCS Administration selects a focus for performance improvement to be measured across Contractors. For each mandated PIP, AHCCCSA develops a methodology to measure performance in a standardized way across Contractors, and manages data collection and analysis. In this way, AHCCCSA ensures that the project is implemented by Contractors in a consistent manner and yields results that can be analyzed by individual Contractor, as well as by other stratifications and for the program overall. In addition, Contractors are required to review their data and quality measures to determine Contractor-specific Performance Improvement Projects.

3) Identifying, collecting and assessing relevant data

Methods may vary given the project. Data sources can include but are not limited to computer-based information, member records, interviews and surveys. The Agency and/or its Contractors may also use an External Quality Review Organization (EQRO) to assist in some or all phases of a project.

4) Providing incentives for excellence and imposing sanctions for poor performance

Beginning in 2003, the AHCCCS Administration began posting aggregate results of performance measures on the AHCCCS website. Web site posting has been expanded to include Contractors' individual performance measure rates. It is expected that the posting will be viewed as an incentive by Contractors to improve their performance rates. The AHCCCS Administration will continue to explore creative ways to provide incentives for performance improvement and positive outcomes.

Corrective action plans (CAPS) are required from Contractors not achieving minimum performance standards. This approach has resulted in a positive trend overall in performance measure rates and a positive impact for AHCCCS members. In order to make the CAP process more robust, AHCCCS requires Contractors to evaluate, at least annually, each corrective action and to determine whether it effectively improves performance. The Agency determines whether Contractors evaluate the effectiveness of these corrective actions during annual site visits.

The AHCCCS Administration provides various incentives, technical assistance, and may impose sanctions if improvement is not achieved. An example of an incentive is the increase in the auto-assignment algorithm for Contractors who demonstrate improved quality of care in two specific performance measures.

5) Sharing best practices

The AHCCCS Administration regularly shares best practices with and provides technical assistance to its Contractors. In addition, Contractors are encouraged to share evidence-based best practices with each other and their providers. An example of this is the sharing of successful interventions during AHCCCS Contractor quality management meetings.

c. Including Medical Quality Assessment And Performance Improvement Requirements In The AHCCCS Contracts

The AHCCCS Administration includes all federally required elements in the contracts and monitors them accordingly.

d. Regular Monitoring And Evaluating Of Contractor Compliance And Performance

The AHCCCS Administration monitors and evaluates access to care, organizational structure and operations, clinical and non-clinical quality measurement and performance improvement outcomes through:

1) Annual on-site Operational and Financial Reviews

AHCCCS conducts annual on-site administrative Operational and Financial Reviews (OFRs) of each Contractor. During an OFR, Agency staff from the Division of Health Care Management (DHCM), the Office of Administrative and Legal Services, the

Division of Business and Finance, and the Office of Program Integrity, observe the operations of health plan personnel, interview key staff and review documentation.

AHCCCS utilizes the OFR process to meet the requirements of the Medicaid Managed Care Regulations (42 CFR 438.364), and to determine the extent to which each Contractor meets the AHCCCS contract requirements, AHCCCS policies, and additional federal and state requirements. AHCCCS also uses the OFR to increase its knowledge of each Contractor's operational and financial procedures, provide technical assistance and identify areas for improvement and areas of noteworthy performance and accomplishment. Additionally, the AHCCCS Administrative staff reviews the progress in implementing the recommendations made during prior OFRs and determines each Contractor's compliance with its own policies and procedures as well as evaluates its effectiveness.

2) Ongoing review and analysis of plans, evaluations, and reports (refer to Section II for more detail) including but not limited to:

   a) Case Management Plan

   b) Cultural Competency Evaluation

   c) Enrollee Appeal and Provider Claim Dispute Report

   d) Enrollee Grievance Report

   e) EPSDT Plan

   f) Maternity Plan

   g) Medical Management Plan and Evaluation

   h) Member / Provider Council Plan

   i) Network Development and Management Plan

   j) Quality Management Plan and Evaluation

   k) Quality Management Quarterly Reports

   l) Service gap reports for Attendant Care, Personal Care, Housekeeping and Respite Care

3) Review and analysis of program-specific performance pleasures and performance improvement projects

On a regular basis, AHCCCS reviews results by Contractor for the quality management performance measures. Results are compared with minimum performance standards specified in contract, and trends are identified. Results of measurements for performance improvement projects also are reviewed and analyzed by Contractor. Appropriate action, such as requiring Contractors to implement corrective action plans and/or providing technical assistance to Contractors, is taken dependent on findings.

4) Meetings and staffings

a) AHCCCS holds semi-annual meetings with Contractors with representation from DHCM administration, operations, finance, quality management, medical management, and encounters to review Contractor performance and discuss identified trends. These meetings also provide for open discussion and serve as opportunities for AHCCCS to offer technical assistance in areas with which a Contractor may be struggling.

b) The DHCM, Office of Administrative and Legal Services and Division of Member Services meet quarterly to share and discuss the performance of the Managed Care Organizations. Areas of review include member services, claims, encounters, quality management, grievance and appeals, medical management, finance and overall operational performance. This meeting affords the Administration with an opportunity to identify individual trends and trends that cross Contractors.

e. Maintaining An Information System That Supports Initial And Ongoing Operations And Review Of The Established Quality Strategy

The AHCCCS Administration uses a statewide, automated managed care data system to support the processing, reporting, research and project needs of the Agency and its Contractors.

The AHCCCS Administration performs extensive data validation. Records of services provided, known as encounter data, are submitted to the Agency for all Medicaid covered services including institutional, professional, dental, and medication/pharmacy services, with each having its own format. The AHCCCS Administration also performs annual validation studies on Contractor data to ensure that the data has been reported timely, and is accurate and complete. In 2005, the Agency established a “data warehouse,” known as the AHCCCS Data Decision Support System (ADDS), which provides a more timely and flexible way to monitor performance measure data, as well as analyze utilization data by type of treatment or provider, and run specialized queries.

f. Reviewing, Revising And Beginning New Projects In Any Given Area Of The Quality Strategy

Review and revision of the components of the Quality Strategy is an ongoing process for AHCCCS. New projects and/or strategies may evolve from current ones. Success with improvements and outcomes is monitored over time for sustainability prior to retiring projects. The process repeats itself for the development of new studies, which are followed by interventions to improve the health and well-being of AHCCCS members.

g. Public Involvement

For the original document, as well as any subsequent substantive changes to the Quality Strategy, the Agency solicits input from the Director's State Medicaid Advisory Committee (SMAC)**.** The Committee includes the Director of AHCCCS; representation from the Native American community; Medicaid members; senior, disabled, and child advocacy communities; nursing facility and home and community based services advocates; the medical community (physician); the Arizona Department of Health Services (ADHS); and the Arizona Department of Economic Security (ADES). SMAC holds open meetings that are regularly attended by citizens, in addition to council members.

h. Frequent Strategy Evaluation

In an effort to maintain a commitment to continuous improvement, the Quality Strategy document is reviewed annually and/or when a significant change occurs. Changes in Agency documents such as policy manuals and contracts are made as appropriate. A significant change is defined as any change to the Quality Strategy that may reasonably be foreseen to materially affect the delivery or measurement of the quality of health care services.

B. Quality Strategy Objectives

AHCCCSA's quality strategy objectives are a component of the Agency's overall Five Year Strategic Plan. The AHCCCS Five Year Strategic Plan provides a high level view of the Agency's quality strategies which are further developed, implemented and reviewed for effectiveness regarding member health outcomes.

1. Quality Strategy Scope

In the formulation of quality strategy objectives, the following are encompassed and considered within the scope of the Quality Strategy:

a. Medicaid Managed Care members in the acute, long-term care, Children's Rehabilitative Services and behavioral health programs.

b. Aspects of care including: coordination, accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by AHCCCS.

c. Aspects of Contractor performance relating to access to care, quality of care and service, including, but not limited to: disease management, preventative care, health promotion, patient care planning, network contracting (includes professional and paraprofessional workforce development) and credentialing, and grievance systems.

d. Professional and institutional care in any setting, including inpatient and outpatient, in-home, and alternative settings.

e. Professional and paraprofessional providers and any other delegated or subcontracted provider types such as providers of transportation or durable medical equipment.

f. Aspects of Contractors' internal administrative processes that are related to service and quality of care. This includes member services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information systems and quality improvement.

2. Five Year Strategy Goals and Objectives

AHCCCS requires the provision of high quality health care and services whose quality can be demonstrated to its members, the community and its funders. AHCCCS has formulated strategies for evidenced-based outcomes and quality initiatives that:

a. Reward quality of care, member safety and member satisfaction outcomes;

b. Support best practices in disease management and preventive health;

c. Provide feedback on quality and outcome to Contractors and providers; and

d. Provide comparative information to consumers.

AHCCCS has adopted the following tenets as part of its five-year goals:

a. Enhance current performance measures and performance improvement projects and best practices activities by creating a comprehensive quality of care assessment and improvement plan across AHCCCS Medicaid programs that serves as a roadmap for driving the improvement of member-centered outcomes. Objectives include:

    1) Continuing use of nationally recognized protocols, standards of care, and benchmarks; and

    2) Continuing use of a system of rewards for providers, in collaboration with ~~its~~ Contractors, based on clinical best practices and outcomes.

b. Build upon prevention efforts and health maintenance/management to improve AHCCCS members' health status through targeted medical management in the following areas:

    1) Emphasizing disease management,

    2) Improving functionality in activities of daily living,

    3) Planning patient care for the special needs population,

    4) Increasing emphasis on preventative care,

    5) Identifying and sharing best practices, and

    6) Exploring Centers of Excellence

c. Develop collaborative strategies and initiatives with state agencies and other external partners. Objectives include continuing use of:

    1) Strategic partnerships to improve access to health care services and affordable health care coverage;

    2) Collaboration with Contractors and providers on best practices in disease prevention and health maintenance;

    3) Partnerships with sister agencies, Contractors and providers to educate Arizonans on health issues;

    4) Effective medical management of at risk and vulnerable populations;

5) Capacity building in rural and underserved areas to address both professional and paraprofessional shortages; and

d. Enhance customer service and improve information retrieval and reporting capability by establishing new and upgrading existing information technologies and thereby increasing responsiveness and productivity. Objectives include:

1) Implementing the Governor's e-Health Roadmap: By 2009, as an awardee of CMS' Medicaid Transformation Grant program, AHCCCS will deploy a statewide health information exchange (HIE) utility, an electronic health record (EHR) central repository, and a web-based system to access and maintain the EHR.

2) Continuing participation in "Arizona Health Querry" – Along with other major providers of health care in Arizona, AHCCCS is a partner in an unprecedented health data system that aggregates and analyzes essential, comprehensive health information for residents of Arizona. Arizona Health Query tracks individuals across systems over time.

3) Continuing enhancement of the AHCCCS data sharing warehouse system in order to enable the end-users quick access to AHCCCS data for a variety of quality and medical management studies.

(The full AHCCCS Five Year Strategic Plan is available at www.azahcccs.gov.)

3. Quality Strategy Progress

Current analysis, progress and results of current and on going performance measures, performance improvement projects and initiatives may be found by accessing the "AHCCCS Reports" and "Initiative" sections noted in the Preface. Additionally, Section II, ASSESSMENT, describes AHCCCS Quality activities including process and examples of results. AHCCCS strives for optimal member health outcomes and member satisfaction as demonstrated by the following examples.

a. **Performance Measures -** AHCCCS was among the first to utilize HEDIS® measures or HEDIS®-like measures for Medicaid managed care. In 2001, AHCCCS implemented a system of Minimum Performance Standards, Goals and Benchmarks for each performance measure, which Managed Care Contractors must meet, or be subject to corrective actions and/or sanctions. The Minimum Performance Standard (MPS) and Goal for each measure are based on an objective methodology designed to "narrow the gap" between the current statewide average and a Benchmark, a longer-range goal specified in contract that is usually based on a comparable "Healthy People" 2010 Goal for improvement.

This system has helped achieve a high level of overall performance in several areas of preventive health, as measured by HEDIS® specifications. For example, the overall average of AHCCCS Contractors for annual dental visits provided to Medicaid enrollees younger than 21 years of age is in the top 10 percent of Medicaid health plans nationally. Other

measures in which the AHCCCS program outperforms the national average for Medicaid health plans are some measures of childhood immunizations and well-child visits in the first 15 months of life.

AHCCCS continues to explore new ways to drive further improvements in performance, including possible Contractor, member and/or provider incentives. The Agency also continues to raise expectations for Contractor performance; for example, by increasing Minimum Performance Standards, to ensure that members receive preventive health care services.

b. **Performance Improvement Projects** – The Agency has a well-developed process for identifying and conducting projects to improve performance in key areas of clinical care and non-clinical services that affect health outcomes and enrollee satisfaction. In 2002, AHCCCS implemented a Performance Improvement Project (PIP) to improve the health of members with diabetes by ensuring they had a specific type of blood test at least once a year and that their blood-glucose levels were considered to be controlled. The project focused on improving blood-glucose testing and laboratory levels for members enrolled with Acute-care and ALTCS Contractors. The PIP resulted in overall rates of testing and control that exceeded the national Medicaid average, with the rate of "poor control" of blood-glucose levels ranking among the best-performing Medicaid health plans in the nation.

c. **Spouse as Paid Caregiver** – To continue to expand the Home and Community Based Services (HCBS) network within ALTCS and allow more choice for ALTCS members, AHCCCS requested and received a waiver from CMS to allow members to select their spouse to be their paid caregiver. Although this may not be a viable option for many members, there are those member/family situations (e.g., working spouse needed to quit his/her job in order to provide the seven day a week, 24 hour per day intermittent care) that will be able to benefit from this option. The Spouse as Paid Caregiver Policy became effective in October, 2007.

d. **Self Directed Attendant Care** – Consumers and advocates have been requesting that AHCCCS develop a Self Directed Attendant Care Program so that members may have more control of and better manage their needs. Led by an ALTCS Program Contractor, the development work teams have included members, providers, advocates and AHCCCS Contractors. Self Directed Attendant Care will encourage members to make decisions that will more likely result in positive outcomes. Program implementation is expected by April 1, 2008.

e. **Collaborative Oversight of Nursing Facilities** – AHCCCS has worked with ALTCS Contractors to coordinate the monitoring and oversight of nursing facilities in the largest Arizona County. This process has reduced the burden on nursing facilities, by reducing the number of AHCCCS Contractors scheduling and conducting quality management reviews allowing them more time for member care and quality improvement activities. In addition, this process has freed time for Contractor resources to evaluate and improve monitoring and oversight of the home and community based program, much of which has far less state licensure oversight.

f. **AHCCCS Data Decision Support System** - In 2005, the Agency implemented a "data warehouse," known as the AHCCCS Data Decision Support System (ADDS), which provides a more timely and flexible way to monitor performance measure data, as well as analyze utilization data by type of treatment or provider, and run specialized queries. When ADDS was developed, the Agency incorporated HEDIS® measures, including many that had not been previously used, into the data warehouse. There are now more than 100 separate measures, ranging from Adolescent Well Care Visits to Use of Imaging Studies for Low Back Pain that can be selected to monitor and improve quality. Results for these measures can be analyzed by individual Contractor, geographic area, race/ethnicity, and specific beneficiary categories. This allows the Agency and its Contractors to target efforts where improvement is needed and likely to be most beneficial.

g. **AHCCCS E-Health Initiative** - Arizona recognizes that early adoption of a statewide e-health information infrastructure will improve the quality and reduce the cost of health care in Arizona. As an awardee of CMS' Medicaid Transformation Grant program, by 2009, AHCCCS will deploy a statewide health information exchange (HIE) utility, electronic health record (EHR) central repository, and a web-based system to access and maintain the EHR. The project is being achieved in cooperation with the public-private coalition, Arizona Health-e-Connection, through the AHCCCS Health Information Exchange and Electronic Health Record Utility.

   Through this electronic utility, all Medicaid providers will have instant access to beneficiaries' health records via electronic connection at the point of service. The HER features available through this utility will include storage and retrieval of personal health information in a common standardized format by authorized users. Implementing this HIE utility will transform the AHCCCS Medicaid program and the member care process. Providing timely member health information at the point of service will improve the quality, efficiency and effectiveness of Arizona's Medicaid program. Real time health information access will result in improved member care through reduction of medical errors, reduction of redundant testing and procedures, better coordination of care for chronic diseases, increased preventive interventions, reduction in the inappropriate use of the emergency room, and lower administrative costs.

SECTION II: ASSESSMENT

The following are key areas related to assessment which the BBA regulations designate as required components of the Agency's overall Quality Strategy. The subject of each segment is followed by its relevant federal citation as a reference.

A. Quality and Appropriateness of Care

1. State assessment of quality and appropriateness of care/services for routine and special health care needs members [42 CFR 438.204(b)(1) & 438.208(c)(1)(i)]

The AHCCCS Administration monitors quality and appropriateness of care/services for routine and special health care needs members through annual Operational & Financial Reviews of Contractors and the review of required Contractor deliverables set forth in contract, program specific performance measures, and performance improvement projects.

Members with special health care needs are those members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member will be considered as having special health care needs if the medical condition simultaneously meets the following criteria:

a. Lasts or is expected to last one year or longer, and

b. Requires ongoing care not generally provided by a primary care provider.

AHCCCS has determined that the following populations meet this definition:

a. Acute care:

   1) Members who are recipients of services provided through the Arizona Department of Health Services Children's Rehabilitative Services (CRS) program,

   2) Members who are recipients of services provided through the Arizona Department of Health Services Division of Behavioral Health contracted Regional Behavioral Health Authorities (RBHAs), and

   3) Members diagnosed with HIV/AIDS.

b. ALTCS:

   1) Members enrolled in the ALTCS program who are elderly and/or physically disabled, and

   2) Members enrolled in the ALTCS program who are developmentally disabled.

Contractors may also choose to identify as members with special health care needs any other members who they determine meet the definition.

As previously noted, AHCCCS utilizes a variety of modalities to implement quality-based projects and initiatives, monitor and support ongoing activities, as well as provide technical expertise. The following are examples of activities in each of the assessment areas.

a. Operational and Financial Reviews (OFR)

AHCCCS conducts annual on-site administrative Operational and Financial Reviews (OFRs) of each Contractor. During an OFR, Agency staff from the Division of Health Care Management (DHCM), the Office of Administrative and Legal Services, the Division of Business and Finance, and the Office of Program Integrity observe the operations of health plan personnel, interview key staff and ~~to~~ review documentation.

AHCCCS utilizes the OFR process to meet the requirements of the Medicaid Managed Care Regulations (42 CFR 438.364), and to determine the extent to which each Contractor meets the AHCCCS contract requirements, AHCCCS policies, and additional federal and state regulations. AHCCCS also uses the OFR to increase its knowledge of each Contractor's operational and financial procedures, provide technical assistance and identify areas for improvement and areas of noteworthy performance and accomplishment. Additionally, the AHCCCS Administrative staff reviews the progress in implementing the recommendations made during prior OFRs and determines each Contractor's compliance with its own policies and procedures as well as evaluates its effectiveness.

To maintain compliance with BBA requirements and the AHCCCS Administration contract standards, AHCCCS reviews the following areas at least every three years**:**

1) Behavioral Health

2) Case Management

3) Claims System

4) Corporate Compliance

5) Cultural Competency

6) Delegated Agreements

7) Delivery System

8) General Administration

9) Grievance System

10) Maternal and Child Health

11) Medical Management

12) Quality Management

13) Reinsurance

14) Third Party Liability

AHCCCS has chosen to review some areas more frequently, sometimes annually. Increased frequency may be due to the area being a new requirement, compliance issues, or areas of specific focus.

b. Contractor Periodic Reporting Requirements (Deliverables)

Required contract deliverables include, but are not limited to:

1) Case Management Plan (annually)

2) Cultural Competency Evaluation (annually)

3) Enrollee Appeal and Provider Claim Dispute Report (quarterly)

4) Enrollee Grievance Report (quarterly)

5) EPSDT Plan (including dental) (annually)

6) EPSDT Progress Report (including dental) (quarterly)

7) Maternity Plan (annually)

8) Medical Management Plan and Evaluation (annually)

9) Member / Provider Council Plan (annually)

10) Network Development and Management Plan (annually)

11) Quality Management Plan and Evaluation (annually)

12) Quality Management Reports (quarterly)

13) Service Gaps for Attendant Care, Personal Care, Housekeeping and Respite Care (Biannually)

The AHCCCS Administration reviews, provides feedback and technical assistance, and approves the various plans as appropriate. For example, annually, Contractors submit their

Quality Management/Performance Improvement (QM/PI) Plans and Evaluations of the previous year's activities, Utilization Management (UM) Plans and Evaluations, Performance Improvement Project (PIP) proposals and reports, annual Maternity Care Plans, annual EPSDT/Dental Plans, and related Work Plans. CQM coordinates this review with other units in the division. On December 15th of each year, DHCM receives annual plans from most Contractors**,** and**,** with other units, reviews them to ensure compliance with AHCCCS and BBA requirements. Quarterly Reports are reviewed and analyzed with follow-up action taken as appropriate.

c. Performance Measures

The Agency uses the HEDIS® to develop, collect and report data for most Performance measures. The results reported are indicators of members' use of services, rather than absolute rates for how successfully the AHCCCS Administration and/or its Contractors provide care. The measures provide trend information, which may provide guidance in designing focused interventions for quality improvement by AHCCCS Contractors. If minimum performance standards (MPS) are not achieved, Contractors are required to develop and submit corrective action plans with interventions that will assist them in meeting MPS. Examples include: measures for adolescent well-care visits, home- and community-based (HCB) services, timely initiation of services including prenatal care, and coordination of care between behavioral health professionals and primary care providers. Performance measure requirements are explicit in contract. Contracts and amendments are located on the AHCCCS website.

The AHCCCS Administration utilizes several methods to encourage improvements in performance measure rates. Beginning in 2003, the Agency began posting aggregate results of performance measures on the AHCCCS website. Website postings include Contractors' individual performance measure rates. These postings provide an incentive for Contractors to improve their rates. The AHCCCS Administration also utilizes corrective action plans to improve rates when MPS are not met. Contractors not meeting the MPS for a specific performance measure must develop and implement interventions focused on improving the rate at which members receive recommended services and must evaluate the effectiveness of corrective actions at least annually. This approach has resulted in a positive trend overall in performance measure rates. The AHCCCS Administration may also change the auto-assignment algorithm at any time during the term of the contract in response to Contractor specific issues.

d. Performance Improvement Projects

The AHCCCS Administration considers a Performance Improvement Project (PIP) to be a planned process of data gathering, evaluation, and analysis to design and implement interventions or activities that are anticipated to have a positive outcome. PIPs are designed to improve the quality of care and service delivery and include:

1) Identifying areas for improvement;

2) Gathering baseline data from administrative data and other sources;

3) Designing and implementing interventions;

4) Measuring the impact of the intervention, and

5) Maintaining/sustaining that improvement.

The Agency may require its Contractors to submit a PIP proposal with its Quality Management Plan. Contractors are also required to submit annual PIP milestone reports as well as final reports. The improvement strategy must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline. Examples of Contractor-selected PIPs currently under way include assessment of appropriate use of medications for members diagnosed with asthma and improving medically necessary transportation for long term-care members.

The AHCCCS Administration also mandates a number of Agency-specified PIPs. Contractors are required to participate, and these may vary by contract type. For example, the required PIP for acute care Contractors may not be the same as for long-term care Contractors. An example of a mandated PIP is the Diabetes Improvement Project, which was completed in 2006, and resulted in improvements in preventive care and outcomes in the management of AHCCCS members diagnosed with diabetes among all Contractors.

After baseline rates for each Contractor are established and interventions to improve performance have been implemented, the Agency and/or the Contractors will remeasure performance for at least two years to achieve the BBA required "sustained improvement." If a Contractor's performance improves as a result of interventions, the PIP will be a minimum of four years in duration.

2. Arrangement for annual external performance review [42 CFR 438.204(d)]

The Agency conducts most of the activities of the Quality Strategy in-house. There are a limited number of Performance Improvement Projects and Performance Measurement Processes conducted directly by an External Quality Review Organization (EQRO). For purposes of BBA compliance, AHCCCS contracts with EQROs to review the quality monitoring activities of AHCCCS and write an independent report regarding each AHCCCS Contractor. These reports identify areas of strength and areas requiring improvement by the Contractor. EQR reports are a driving force in assessing the effectiveness of the Quality Assessment & Performance Improvement Strategy document.

3. State procedures for identifying race, ethnicity, and primary language of each member [42 CFR 438.204(b)(2)]

The AHCCCS Administration receives the member's race and ethnicity, and primary language information from the eligibility source, which collects this information at the time of application.

This information is systematically updated on the AHCCCS member record file and transmitted daily to the Contractor on the member enrollment roster. Changes to this information are also updated and transmitted to the Contractor.

The Contractor communicates to the Agency any member information collected by the Contractor that is different from what was initially provided to them. The AHCCCS Administration updates the member information as appropriate.

This information is included on the data exchange file received from the Social Security Administration. If the information is missing, the system will default to unknown or unspecified. See the previous paragraph for discussion of the information communicated from the Contractor. The AHCCCS Administration continues to evaluate this area and establishes other procedures if necessary.

The AHCCCS Administration has identified seven race and ethnicity categories as follows:

a. Asian/Pacific Islander

b. Black

c. Cuban/Haitian

d. Caucasian/White

e. Hispanic

f. Native American

g. Unknown/Unspecified

h. Other

If the member does not provide or does not wish to provide this information, he will be designated as unknown/unspecified.

Currently there are codes for 40 languages that can be captured electronically. The AHCCCS Administration periodically assesses the language data to determine the need to expand the possible language categories. To date, the prevalent languages in the AHCCCS population are English and Spanish.

B.(1) MCO/PIHP Requirements

AHCCCS MCOs and PIHPs are required as specified in contract, Section D and Attachment H, as well as in the AHCCCS member information policy, to provide members with information including, but not limited to, the following: covered services, how to obtain services, how to choose a provider, their rights with respect to grievances and state fair hearings, prior authorization, advance directives, what constitutes an emergency, language and cultural competency requirements, and the member's financial responsibilities.

1. State standards at least as stringent as those in Sub-part D for: access to care, structure and operations, and quality measurement and improvement [42 CFR 438.204(g)]

The contracts between the AHCCCS Administration and its MCOs and PIHPs define the standards for access, structure and operations, and quality measurement and improvement. Section D of the acute care contract is attached as an example. The AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractors Operations Manual (ACOM)**,** as well as other AHCCCS policies and manuals, are incorporated by reference as part of the MCO/PIHP contracts and provide more detailed **STANDARDS** information and requirements.

2. Enrollee Information (42 CFR 438.218 & 438.10)

42 CFR 438.10 sets forth the requirements for both the AHCCCS Administration and its Contractors regarding the dissemination of information to enrollees. In addition to the information specified in Section II (A) (3) of this text, the AHCCCS Administration Processes also include:

a. The application for AHCCCS Health Insurance (AHI) complies with all BBA requirements concerning potential enrollees. When an application form other than the AHI application is used, a supplementary stand-alone document is included with the application. The stand-alone document complies with all of the BBA and pre-enrollment requirements, and is given or mailed to the applicants at the time of their application.

b. The eligibility staff have access to the provider listing by Contractor for their geographic service area (GSA) and will share this with the applicant.

c. Vital documents are available in Spanish. Spanish is currently the only prevalent non-English language in Arizona. Bilingual staff are available in key areas, and the AHCCCS Administration has a contract with *Language Line Services* to facilitate oral interpretation of other languages. When necessary, additional communication accommodations are provided for applicants who have visual, auditory, and/or other impairments.

The AHCCCS administration also provides links to the AHCCCS Contractors' web sites. This enables applicants to view the Contractor networks from the AHCCCS Web site.

3. Information system that supports initial and ongoing operations and review of established quality strategy [42 CFR 438.204(f)]

The AHCCCS Administration has mechanisms in place to ensure that its Contractors maintain information systems that collect, analyze, integrate, and report data, and can achieve the objectives of the AHCCCS program. Contractors are required to maintain claims processing and management information mechanisms sufficient to support provider payments and data reporting between themselves and AHCCCS. Contractors must also collect service-specific procedures and diagnosis data, encounters, and maintain detailed records of remittances to providers. The AHCCCS Administration assesses data accuracy and completeness.

The AHCCCS Administration uses a statewide, automated managed care data system to meet the processing and reporting needs of the MCOs and PIHPs. The system is known as the Prepaid Medical Management Information System (PMMIS). It is composed of eleven core subsystems, five reporting and quality oversight subsystems, and a security subsystem. PMMIS has extensive information~~,~~ retrieval~~,~~ and reporting capabilities to satisfy the data needs of the Agency, CMS, other state and federal agencies, counties, Contractors, providers and members. The system processes Contractor encounters for all AHCCCS members as well as supports the monitoring of service utilization, quality of care, and program expenditures. PMMIS is a mature system that has been modified over time to accommodate the growing and changing needs of the AHCCCS program.

In 2005, the Agency implemented a "data warehouse," known as the AHCCCS Data Decision Support System (ADDS), which utilizes data loaded from the PMMIS to provide a timely and flexible way to collect and analyze a variety of data overall and by individual Contractor. These data include performance measures, utilization data (including the ability to conduct analyses by type of treatment or provider), recipient enrollment and demographic information, and specialized queries. When ADDS was developed, the Agency incorporated HEDIS® measures, including many that had not been previously used, into the data warehouse. There are now more than 100 separate measures, ranging from Adolescent Well Care Visits to Use of Imaging Studies for Low Back Pain that can be selected to monitor and improve quality. Results for these measures can be analyzed by individual Contractor, geographic area, race/ethnicity, and specific beneficiary categories. This allows the Agency and its Contractors to target efforts where improvement is needed and likely to be most beneficial. ADDS data for performance measures is compared with performance measure data reported by Contractors to identify trends and potential completeness or reliability discrepancies.

B. (2) MCO/PIHP Contractual Compliance

1. State standards at least as stringent as those in Sub-part D for: access to care, structure and operations, and quality measurement and improvement [42 CFR 438.204(g)]

The contracts between the AHCCCS Administration and its MCOs and PIHPs describe the Agency's standards for access, structure and operations, and quality measurement and improvement. Section D of the acute care contract is attached as an example. The AHCCCS Medical Policy Manual (AMPM), and the AHCCCS Contractors Operations Manual**,** as well as other AHCCCS policies and manuals, are incorporated by reference as part of the MCO/PIHP contracts and provide more detailed information on standards requirements.

2. State verification that Sub-Part D provisions of the BBA regulations are included in Medicaid contract provisions [42 CFR 438.204(a)]

The AHCCCS Administration incorporates in its MCO (Health Plans & Program Contractors) and PIHP (ADHS/DBHS & CRS) contracts the Sub-Part D provisions, which include standards for:

a. Access to care (availability and adequate capacity of services, coordination and continuity of care, and coverage and authorization of services),

b. Structure and operations (provider selection, confidentiality, and grievance system), and

c. Quality measurement and improvement provisions (practice guidelines, quality assessment, performance improvement and health information systems).

3. Regular state monitoring and evaluation of MCO and PIHP compliance [42 CFR 438.204(b)(3) & 438.416]

The AHCCCS Administration monitors and evaluates Contractor compliance through annual Operational and Financial Reviews (OFR), the review and analysis of periodic reports as required in the contract, program specific Performance Measures, and Performance Improvement Projects. In addition to the information provided in Section II (A) (1), the following is a description of the broad spectrum of the OFR. In order to ensure a Contractor's operational and financial program compliance with its contract with the AHCCCS Administration, the AHCCCS review team:

a. Determines if the Contractor satisfactorily meets AHCCCS requirements as specified in contract, policy and federal/state regulations;

b. Reviews the Contractors' progress toward implementing the recommendations made during the previous review;

c. Reviews outcomes of interventions for Performance Measures and Performance Improvement Projects;

d. Reviews records of appeals for timeliness and appropriateness;

e. Determines if the Contractor is in compliance with its own policies and procedures, and evaluates the effectiveness of those policies and procedures;

f. Provides technical

g. Identifies areas which could be improved, as well as identifying areas of noteworthy performance and accomplishment;

h. Conducts interviews or group conferences with members of the Contractor's administrative staff; and

i. Examines the Contractors' records, books, reports, and information systems, and/or those of any management company as necessary.

As a condition of its 1115 Waiver, the AHCCCS Administration performs extensive data validation. Known as encounter data, records of services provided are submitted to the Agency for all Medicaid covered services including institutional, professional, dental, and medication/pharmacy services, with each having its own format. The AHCCCS Administration also performs annual validation studies on Contractor data to ensure that the data has been reported timely, is accurate, and complete. Since sanctions may be imposed on the Contractor, based on the results of the data validation studies, the Agency provides technical assistance and training to the Contractors to support the Contractor's ability to meet the AHCCCS Administration requirements. OFR and data validation results are reported to CMS in accordance with the 1115 Waiver Terms and Conditions.

Through its collaboration with the CMS, the AHCCCS Administration maintains a "checklist for managed care contract approval". This checklist provides detailed explanations of standards and indicates where standards are located in the contract.

4. <u>For MCOs, intermediate sanctions that meet the requirements of Sub-Part I [42 CFR 438.204(e)]</u>

The AHCCCS Administration may impose monetary sanctions, and/or suspend, deny, refuse to renew, or terminate a contract or any related subcontracts in accordance with Arizona Administrative Code, R9-22-606, and the terms of the contract and applicable Federal or State regulations. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for the sanction, and either the length of suspension or the amount of capitation prepayment to be withheld. The Contractor may appeal the decision to impose a sanction in accordance with 9 A.A.C. 34. Intermediate sanctions may be imposed for, but are not limited to the following actions:

a. Substantial failure to provide medically necessary services that the Contractor is required to provide**,** under the terms of its AHCCCS contract, to its enrolled members;

b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver;

c. Discrimination among members on the basis of their health status or need for health care services;

d. Misrepresentation or falsification of information furnished to CMS or AHCCCSA;

e. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider;

f. Failure to comply with the requirement for physician incentive plan as delineated in contract;

g. Distribution directly, or indirectly, through any agent or independent contractor, of marketing materials that have not been approved by AHCCCSA or that contain false or materially misleading information;

h. Failure to meet AHCCCS Financial Viability Standards;

i. Material deficiencies in the Contractor's provider network;

j. Failure to meet quality of care and quality management requirements;

k. Failure to meet AHCCCS encounter standards;

l. Violation of other applicable state or federal laws or regulations;

m. Failure to fund accumulated deficit in a timely manner;

n. Failure to increase the Performance Bond in a timely manner; and

o. Failure to comply with any other contract provisions.

The AHCCCS Administration may impose the following types of intermediate sanctions:

a. Civil monetary penalties;

b. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706 and A.R.S. §36-2903;

c. Allowing members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll;

d. Suspension of all new enrollment, including auto assignments, after the effective date of the sanction;

e. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCSA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur; and

f. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Cure Notice Process:

Prior to the imposition of a sanction for non-compliance, the AHCCCS Administration may provide a written cure notice to the Contractor regarding the details of the non-compliance. The cure notice will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, the Agency may take no further action. If, however, the Contractor has not complied with the cure notice requirements, the AHCCCS Administration will proceed with the imposition of sanctions.

The AHCCCS Administration's Sanctions Policy describes Contractors requirements in accordance with 42 CFR 438, Subpart I. The policy cites the types of sanctions and subsequent monetary penalties or other actions that may result if a Contractor fails to adhere to the provisions of the Medicaid Managed Care program or contractual requirements.

C. Evolution of Health Information Technology

1. Information system that supports initial and ongoing operations and review of established quality strategy [42 CFR 438.204(f)]

The AHCCCS Administration has mechanisms in place to ensure that its Contractors maintain information systems that collect, analyze, integrate, and report data, and can achieve the strategy objectives of the AHCCCS program. Contractors are required to have available claims processing and management information sufficient to support provider payments and data reporting between themselves and AHCCCS. Contractors must also collect service-specific procedures and diagnosis data, encounters, and maintain detailed records of remittances to providers. The AHCCCS Administration assesses Contractors' data accuracy and completeness.

PMMIS - The AHCCCS Administration uses a statewide, automated managed care data system to satisfy the processing and reporting needs of the MCOs and PIHPs. The system is known as the Prepaid Medical Management Information System (PMMIS). It is composed of eleven core subsystems, five reporting and quality oversight subsystems, and a security subsystem. PMMIS provides extensive information, retrieval, and reporting capabilities to satisfy the data needs of the Agency, CMS, other state and federal agencies, counties, Contractors, providers and members. The system processes Contractor encounters for all AHCCCS members as well as supports the monitoring of service utilization, quality of care, and program expenditures. PMMIS is a mature system that has been modified over time to accommodate the growing and changing needs of the AHCCCS program.

ADDS - In 2005, the Agency implemented a "data warehouse," known as the AHCCCS Data Decision Support System (ADDS), which utilizes data loaded from the PMMIS to provide a timely and flexible way to collect and analyze a variety of data overall and by individual Contractor. These data include performance measures, utilization data (including the ability to conduct analysis by type of treatment or provider), recipient enrollment and demographic information, and specialized queries. When ADDS was developed, the Agency incorporated HEDIS® measures, including many that had not been previously used, into the data warehouse. There are now more than 100 separate measures, ranging from Adolescent Well Care Visits to Use of Imaging Studies for Low Back Pain that can be selected to monitor and improve quality. Results for these measures can be analyzed by individual Contractor, geographic area, race/ethnicity, and specific beneficiary categories. This allows the Agency and its Contractors to target efforts where improvement is needed and likely to be most beneficial. ADDS data for performance measures is compared with performance measure data reported by Contractors to identify trends and potential gaps in completeness or reliability**.**

AHCCCS E-Health Initiative - By 2009, the AHCCCS health information exchange (HIE) utility, electronic health record (EHR) repository, and a web-portal will be fully deployed to achieve the goal of giving all Medicaid providers instant access to beneficiaries' health records via electronic connection at the point of service.

Implementing this HIE utility will transform the AHCCCS Medicaid program and the member care process. Providing timely member health information at the point of service will improve the quality, efficiency and effectiveness of Arizona's Medicaid program. Real time health information access will result in reduction of medical errors, reduction of redundant testing and

procedures, better coordination of care for chronic diseases, increased preventive interventions, reduction in the inappropriate use of the emergency room, and lower administrative costs. When aggregated, these benefits will save significant state and federal taxpayer dollars (in Medicaid, SCHIP, and IHS) as well as alleviate beneficiary and provider frustration.

In addition to the extensive current encounter and claims data warehouse described in this section, the AHCCCS HIE-EHR Utility will transform the capacity for improvement of the quality, efficiency and effectiveness of Arizona's Medicaid program. The Health Information Exchange data warehouse and databases, health information web portal and web based health information applications will facilitate the exchange and management of personal health and demographic information for AHCCCS members, including:

a. Eligibility information,

b. Lab data lab order entry,

c. E-Prescribing and medication list, and

d. Other personal health information.

In accordance with the Healthcare Information Portability and Accountability Act (HIPAA), custodians of patient-identifiable information must take appropriate steps to ensure the security of that information commensurate with the size and resources of the custodian's organization. The AHCCCS HIE-EHR Utility site will be protected by multiple levels of firewalls and will require user log-on and authentication to pass credentials to meet HIPAA requirements.

The proposed HIE utility will also provide the infrastructure to support the goals of the Quality and Cost Transparency Initiatives of President Bush and Secretary Leavitt by making relevant information available to Medicaid beneficiaries and providers in a user-friendly format. Specific components of the database include:

a. Clinical notes contents and database,

b. Master provider index database,

c. Master patient index database,

d. Laboratory order entry and results reporting,

e. E-prescribing and medication list,

f. Patient chronic illness registry database,

g. Radiology imaging database,

h. Public health alert and instant messaging,

i. EPSDT automated encounter,

j. Managed care health plan on-line drug formulary,

k. Case management record database and information exchange,

l. Hospital discharge record database and exchange,

m. On-line authorization and referral,

n. On-line professional claims processing, and

o. Personal health record.

SECTION III: IMPROVEMENT/INTERVENTION

AHCCCS has numerous process improvement and intervention strategies in place to achieve the goals and objectives noted in the "Quality Strategy Objectives" portion of Section I B. The general and specific methodologies used by AHCCCS are thoroughly explained in Sections I and II. Specific activities and progress are described in the AHCCCS Reports noted in the Preface.

AHCCCS has several projects under development as well as under consideration pending baseline reporting of targeted information. The following are key initiatives and interventions under development:

A. AHCCCS E-Health Initiative

In addition to the information provided in Section II, the initiative will:

1. Facilitate the connection of 35% of AHCCCS providers, who will be actively sharing electronic health information through the HIE utility by the end of 2009. 60% of AHCCCS providers will be connected by the end of 2010. By the end of 2011, more than 90% of the providers will be included.

2. Improve quality of care oversight and quality transparency through the provision of timely performance information.

3. Improve care coordination for chronic diseases, and foster better coordination between behavioral health and physical health services.

4. Enhance opportunities for better self-management of chronic illnesses by beneficiaries and their families through access to personal health information and online wellness materials.

B. Pay for Performance

1. AHCCCS participates in a Center For Health Care Strategies (CHCS) grant that focuses on developing pay for performance programs in Medicaid.
2. Pay for performance programs under consideration focus on diabetes care, asthma, and care provided in nursing homes.
3. Funding for the pay for performance programs will be requested from the Arizona legislature.

C. Return on Investment

1. AHCCCS is involved in a CHCS grant focused on return on investment. AHCCCS has linked this project to the CHCS pay for performance grant.
2. AHCCCS will be utilizing a CHCS developed tool to calculate what the return on investment would be for implementing interventions to improve quality of care outcomes.
3. Outcomes from this project will be utilized to evaluate the value of investing in pay for performance programs related to other initiatives.

D. Self-Directed Attendant Care

Consumers and advocates have been requesting that AHCCCS develop a Self Directed Attendant Care program to enable members to have more control of and better manage their care needs. Providing members with more options, such as what is allowed under Self Directed Attendant Care, will empower them to make decisions that will more likely result in positive outcomes. Program implementation is expected by April 1, 2008.

E. Increased Contractual Performance Standards

Under consideration pending baseline reporting of targeted information are revisions to the contractual Performance Standards that would better align minimum performance levels and benchmarks with the most current HEDIS® means and percentiles for Medicaid managed care organizations, as reported by the National Committee for Quality Assurance. This mechanism is designed to ensure that, overall, measures of quality meet or exceed national averages for Medicaid enrollees.

SECTION IV: STRATEGY EFFECTIVENESS

In general the effectiveness of the strategies described in this document can be evaluated by the data that is collected and analyzed on an ongoing basis; trends; and comparisons with goals and benchmarks that are established and reviewed on a continuum. Examples of these data include results of performance measures and performance improvement projects, as well as other data reported by Contractors, such as quality of care concerns**.** The frequency of the evaluations and the reporting requirements are noted in Section II of this document and in Contract. The Quality Assessment & Performance Improvement Strategy is considered a companion document to the EQRO reports.

The EQR reports encompass specific details of the assessment, results and recommendations related to the goals and strategies found in this document. This information is used to assess the effectiveness of the currently stated goals and strategies and provides a roadmap for potential changes and new goals/strategies. For review of this information for the acute & long term care MCOs and the PIHPs, refer to the AHCCCS website as noted in the preface.

Strategy effectiveness, progress and updates for the Quality Assessment and Performance Improvement Strategy are also reported in Attachment II, "Quality Assurance/Monitoring Activity" of the Section 1115 Quarterly Report**.** This report describes Quality Assurance/Monitoring Activities of AHCCCS during the quarter, as required in STC 26 of the State's Section 1115 Waiver. The report also includes updates on implementation of the AHCCCS Quality Assessment and Performance Improvement Strategy, in accordance with Balanced Budget Act (BBA) requirements. The report may be found on the AHCCCS website as noted in the preface.

SECTION V: CONCLUSION

Improving and/or maintaining members' health status as well as increasing the potential for resilience and functional health status for members with chronic conditions is at the core of the quality strategy. AHCCCS uses a variety of modalities to drive quality through the system to achieve improvements and successes. AHCCCS' culture of quality is sustained by the combination of oversight and collaboration provided in the form of:

1. OFRs, which identify accomplishments and areas of improvement. The OFR is an effective vehicle for discovering best practices that can be shared with all Contractors. Corrective Action Plans (CAPs) are developed as necessary. CAPS function as a tool to follow up where improvement is needed;

2. Performance Measures, such as standards for childhood immunization rates, which demonstrate an overall improvement and for which corrective measures are in place as necessary;

3. Performance Improvement Projects, such as the diabetic project, increased child access to PCPs, and increased adult access to preventative ambulatory health, which have had an overall positive impact;

4. Consumer inspired projects such as the spouse as paid caregiver program**,** which continues to expand the ALTCS HCBS network and provides more choices for ALTCS members;

5. Collaborative projects, such as the coordination of the oversight of nursing facilities, which has reduced the burden on nursing facilities and freed time for Contractor resources to evaluate and improve monitoring and oversight of the home and community based program, much of which has far less state licensure oversight;

6. Federal initiatives, such as that led by the Agency for Healthcare Research and Quality (AHRQ), which is focusing on collaborative opportunities to develop quality-based pay-for-performance programs. Working with other states and employers in Community Purchasing Groups, AHCCCS is participating in the development of a pay-for-performance program that rewards evidence-based care resulting in quality outcomes to members, and discourages negative outcomes;

7. Federal/State Systems based initiative that will enhance member self-management and provide more immediate access to member information for physicians**,** and

8. A continual flow of information and synergy with all stakeholders as noted in this document.

Although AHCCCS has experienced significant quality improvements and successes as demonstrated by the Reports noted in the Preface, the Agency and its Contractors continuously strive for:

1. Improved performance by Contractors as a result of incentives such as comparative reporting and financial advantages;

2. Informed members, who understand the value of preventive care; and, for those members with chronic diseases, the ability to maintain or increase their health;

3. A physician community that is increasingly vested in the prevention of disease;

4. Systematic research and sharing of best practices and lessons learned both locally and nationally;

5. A significant reduction in the costs associated with treating disease and adverse health outcomes;

6. Broader participation in collaborative community efforts to improve the health status of Arizonans;

7. Identification of centers of excellence; and

8. Provision of technical assistance programs with subject matter experts.

The AHCCCS Administration has long been respected as an innovator in the area of Medicaid managed care. It is our commitment to quality and our desire to continue that history of innovation and continuous improvement that has helped Arizona remain in the forefront. Despite the challenges, AHCCCSA is committed to increasing its pro-active role as a "quality of care improver," while maintaining its traditional role as the monitor of quality of care. AHCCCS looks forward to ~~its~~ continued partnerships and collaborations in meeting this challenge.